

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER CELINA HEALTH AND REHABILITATION CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CELINA, TN 38551		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments An annual licensure survey was completed at Celina Health and Rehabilitation Center on July 8 - 10, 2013. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	times per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Paul Boone

TITLE

Administrator

(X6) DATE

7/17/13

6899

2PXW11

If continuation sheet 1 of 1

JUL 22 2013